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VA Announced Today That Four Veterans Have Positive Tests; Pledged To Provide Vets, Families with Care and Counseling

(WASHINGTON, DC) - Congressman Russ Carnahan (MO-03) said today that while he was glad to hear that the Department of Veterans Affairs is providing care and counseling to four veterans who have tested positive for Hepatitis B and C in the wake of safety lapses at John Cochran VA Medical Center, he remains troubled by apparent delays in notifying veterans who had preliminary positive test results.

"I'm deeply saddened to hear that there are veterans who have tested positive, and it is very good to hear that the VA will be taking care of these individuals. We should expect nothing less."

During a briefing with Congressional staff today, VA officials indicated that of 1,022 veterans who have been tested and notified of their results, four have newly tested positive - two with Hepatitis B and two with Hepatitis C. Three of these individuals have never been tested before; one had tested negative previously several years ago, and is now positive. The VA said that it was impossible to know with certainty whether the transmission occurred as a result of the problems with the sanitization process at the Cochran dental clinic, but that they would make sure that the sick veterans and their families received the care and counseling they needed.

The VA also indicated during the briefing that as they have received preliminary positive test results, they have waited to notify the veterans in question until confirming the results with follow-up tests - a delay that Carnahan has called unacceptable.

"I have grave concerns about how the VA is notifying veterans. If there were any individuals who tested positive, even if those results were preliminary, the VA should not have kept them in the dark. They should have been notified immediately so they could seek treatment and take precautions to protect their spouses and loved ones."

Yesterday, Carnahan announced that the Inspector General of the VA has agreed to launch an official investigation into the Cochran matter; the Government Accountability Office (GAO) - the "watchdog" arm of Congress - is broadening the scope of an existing investigation into sanitization procedures at several VA facilities across the country to include Cochran.

"These independent investigations are critical to make sure we have a full understanding of what happened so we can identify and fix any systemic problems that made such a grave error possible," Carnahan said.

Veterans and family members who may have further questions or concerns are urged to contact Congressman Russ Carnahan's office at 314-962-1523.

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